Health 2 Work

OW ID#

Health2Work Report of Findings

Patient Information

First Name	Last Name

DOB (mm/dd/yyyy)	Phone #	Gender

Home Address	Postal code

Diagnosis/Clinical Impression:

Recommended Duration of Chiropractic Care:

# of visits: (Max 10)		Estimated timeline:	

Recommended Plan of Management:

- ☐ Education/self-management
- ☐ Manual Therapy
- ☐ Modalities
- ☐ Referral
- ☐ Other

Notes:

Home Advice:

Coping strategies:	
Pain Relief:	
Exercise:	

Additional Comments:

1. Please indicate **abillties** that apply.

Walking:
- ☐ Full abillties
- ☐ Up to 100 metres
- ☐ 100 - 200 metres
- ☐ Other (please specify)

Standing:
- ☐ Full abillties
- ☐ Up to 15 minutes
- ☐ 15 - 30 minutes
- ☐ Other (please specify)

Sitting:
- ☐ Full abillties
- ☐ Up to 30 minutes
- ☐ 30 minutes - 1 hour
- ☐ Other (please specify)

Lifting from floor to waist
- ☐ Full abillities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Lifting from waist to shoulder:
- ☐ Full abillities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Stair climbing:
- ☐ Full abillties
- ☐ Up to 5 steps
- ☐ 5 - 10 steps
- ☐ Other (please specify)

Ladder climbing:
- ☐ Full abillties
- ☐ 1 - 3 steps
- ☐ 4 -6 steps
- ☐ Other (please specify)

Travel to work

Abillity to use public transit
- ☐ yes
- ☐ no

Abillity to drive a car
- ☐ yes
- ☐ no

2. Please indicate **restrictions** that apply.

- ☐ Bending/twisting re-petitive movement of (please specify)
- ☐ Work at or above shoulder activity: (please specify)
- ☐ Limited use of hand(s):

	Left	Right
Gripping	☐	☐
Pinching	☐	☐
Other	☐	☐

- ☐ Limited pushing/ pulling with:
  - ☐ Left arm
  - ☐ Right arm
  - ☐ Other

- ☐ Operating motorized equipment:(e.g. forklift)
- ☐ Consult required to determine impact of drugs or other medical conditions
- ☐ Exposure to vibration
  - ☐ Whole body
  - ☐ Hand/Arm

Additional comments on functional abilities and/or restrictions:

Employment/Training:

Current status

- ☐ Currently in training program
- ☐ Currently employed part-time
- ☐ Currently employed full-time
- ☐ Currently unemployed/not in training program

Comments:

Desired employment/training plan patient is interested in:

Anticipated barriers for desired employment/training plan (if any):

- ☐ Current pain
- ☐ Decreased range of motion
- ☐ Loss of strength
- ☐ Other (please specify)

Comments:

Plans to Overcome Barriers (if applicable):

- ☐ Chiropractic treatment
- ☐ Stretching
- ☐ Strengthening
- ☐ Strategies to deal with flare ups
- ☐ Other (please specify)

Comments:

Recommendations for suitable employment path or programs:

- ☐ Ready to pursue desired training plan while receiving care
- ☐ Ready to pursue desired employment plan while receiving care
- ☐ Desired employment/training plan should be ok once treatments are complete
- ☐ Desired employment/training plan not suitable based on physical assessment, will be re-evaluated at end of plan of management
- ☐ Current plan not suitable based on existing injuries, alternative career planning recommended

Comments:

Recommended Resources

CCGI Exercise Videos
https://www.chiropractic.ca/guidelines-best-practice/exercise-videos

Take Charge Chronic Pain Workshop
https://www.wwselfmanagement.ca/Individual-Take-Charge-Chronic-Pain.htm